Complete Summary

GUIDELINE TITLE

HIV prophylaxis following occupational exposure.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. HIV prophylaxis following occupational exposure. New York (NY): New York State Department of Health; 2008 Jan. 22 p. [17 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: New York State Department of Health. HIV prophylaxis following occupational exposure. New York (NY): New York State Department of Health; 2004 Jun. 41 p.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Hepatitis B virus (HBV) infection
- Hepatitis C virus (HCV) infection

GUIDELINE CATEGORY

Counseling
Evaluation

Management
Prevention

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Clinical Laboratory Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To develop guidelines for effective post-exposure prophylaxis of human immunodeficiency virus (HIV) and hepatitis B and C virus following occupational exposure in health care workers

TARGET POPULATION

Health care workers after occupational exposure to human immunodeficiency virus (HIV) or hepatitis B virus or hepatitis C virus

INTERVENTIONS AND PRACTICES CONSIDERED

Management of Occupational Exposure to Human Immunodeficiency Virus (HIV)

1. Recording information about the occupational exposure to HIV in the health care worker's confidential medical record
2. Cleansing of wound and skin sites exposed to HIV
3. Voluntary HIV testing after specific informed consent
4. Use of rapid blood test for HIV testing, followed by Western blot assay for confirmation
5. Initiation of post-exposure prophylaxis (PEP) with highly active antiretroviral therapy (HAART), including zidovudine (ZDV, AZT, Retrovir) + lamivudine (3TC, Epivir) (or Combivir) plus tenofovir (Viread).
6. Initiation of alternative PEP agents (zidovudine plus emtricitabine (FTC, Emtriva) + tenofovir)
7. Baseline confidential HIV testing within 72 hours of initiating HAART
8. Referral to experienced clinician within 72 hours of initiating HAART
9. Close monitoring of individuals receiving PEP

10. Special considerations for pregnant healthcare workers exposed to HIV, including counseling on risks and benefits of HAART to the woman and her fetus

Management of Occupational Exposure to Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV)

1. Initiation of hepatitis B vaccine series to workers with potential exposure to blood and body fluids
2. Administration of hepatitis B immune globulin and initiation of hepatitis B vaccine series if worker is exposed to a source patient with acute or active hepatitis B
3. Determination of source patient's HBV and HCV serologic status
4. Baseline HCV serology and serum alanine aminotransferase, with repeated assessments at 4 and 6 months
5. HCV antibody and qualitative HCV viral load (HCV ribonucleic acid polymerase chain reaction)
6. Referral to clinician with experience in treating HCV

MAJOR OUTCOMES CONSIDERED

- Rate of transmission of human immunodeficiency virus (HIV), or hepatitis B virus (BHV) or hepatitis C virus (HCV) from an occupational exposure
- Efficacy of post-exposure prophylaxis (PEP) in reducing risk of transmission
- Risk of toxicity or other adverse effects from medications used for PEP

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

* Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines. These guidelines have also been compared with recommendations published by the Centers for Disease Control and Prevention (see Appendix B of the original guideline document).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Rationale for Post-Exposure Prophylaxis (PEP)

The Committee recommends the use of highly active antiretroviral therapy (HAART) regimens for all significant-risk occupational exposures when the health care worker (HCW) is evaluated within 36 hours of exposure.

Recording Information Following Occupational Exposure

When an occupational exposure occurs, the following information should be recorded in the HCW's confidential medical record:

- Date and time of the exposure
- Details of the procedure being performed and the use of protective equipment at the time of the exposure
- The type, severity, and amount of fluid to which the HCW was exposed
- Details about the exposure source
- Medical documentation that provides details about post-exposure management

General Management Considerations

Wound and skin sites should be cleansed with soap and water immediately. Exposed mucous membranes should be flushed with water.

PEP is recommended for exposure to blood or visibly bloody fluid or other potentially infectious material (e.g., semen; vaginal secretions; and cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids) associated with potential human immunodeficiency virus (HIV) transmission and in any of the following exposure situations:

- Break in the skin by a sharp object (including both hollow-bore and cutting needles or broken glassware) that is contaminated with blood, visibly bloody fluid, or other potentially infectious material, or that has been in the source patient's blood vessel

- Bite from an HIV-infected patient with visible bleeding in the mouth that causes bleeding in the HCW
- Splash of blood, visibly bloody fluid, or other potentially infectious material to a mucosal surface (mouth, nose, or eyes)
- A non-intact skin (e.g., dermatitis, chapped skin, abrasion, or open wound) exposure to blood, visibly bloody fluid, or other potentially infectious material

If HIV serostatus of the source is unknown, voluntary HIV testing of the source should be sought. In New York State, specific informed consent for HIV testing is required.

If rapid blood testing is available on site, it should be used to determine the HIV status of the source patient. Results are usually available within 30 minutes of testing. Rules regarding confidentiality and consent for this testing are identical to those for other HIV tests.

If the preliminary rapid test result is positive, the result should be given to the source patient. To establish a diagnosis of HIV infection, the test must be confirmed by a Western blot assay, which should be performed as soon as possible.

If the result from testing the source patient is not immediately available and PEP is indicated based on assessment, the initiation of PEP should not be delayed pending the test result.

The New York State Department of Health/AIDS Institute (NYSDOH AI) Medical Care Criteria Committee believes that the critical decision point should be to determine whether the HCW has had a percutaneous, mucocutaneous, or non-intact skin exposure to potentially HIV-infected blood, visibly bloody fluid, or other potentially infectious material. For these exposures, prompt initiation of PEP followed by telephone or in-person consultation with a clinician experienced in HIV PEP is recommended.

Implementing PEP

PEP should be initiated as soon as possible, ideally within 2 hours and no later than 36 hours post-exposure. The prescribing provider should ensure that the HCW has access to the full course of antiretroviral (ARV) medications.

HAART is always recommended for at-risk exposures. Any variance from the recommended regimens should be made in consultation with an HIV Specialist or an occupational health clinician experienced in providing PEP (see *HIV Specialist Policy* in Appendix I of the original guideline document).

ARV medications for PEP should be readily available to HCWs who sustain a known or highly suspect occupational exposure to HIV. In establishing plans for providing PEP, employers should determine the following:

- How PEP will be made available within 1 to 2 hours of an exposure
- How a 24- to 48-hour supply of PEP will be made available for urgent use
- Who will be given authority for releasing drugs for this purpose

- How the HCW will obtain PEP drugs to complete the 4-week regimen (some individuals may be reluctant to go to their local pharmacy)

Confidential baseline HIV antibody testing of the HCW should be obtained at the time the occupational exposure is reported or within 72 hours of initiating PEP.

Confidential HIV testing of the source should be obtained as soon as possible after the exposure. A special consent form for testing the source patient is available and must be used (see Appendix C in the original guideline document).

If the source patient's HIV test result is negative, the HCW should be informed of the small chance that it could be a false-negative result if the source patient has been recently infected. PEP should be recommended in situations when a significant risk exposure has occurred and the clinician suspects that the source patient has a strong likelihood of having recently acquired HIV infection.

If a recommendation to begin PEP is declined, this decision should be documented in the medical record of the HCW.

All patients placed on PEP should be re-evaluated within 72 hours of their exposure. This allows for further clarification of the nature of the exposure, review of available source patient serologies, and evaluation of adherence to and toxicities associated with the PEP regimen.

A total of 4 weeks of treatment is recommended. This treatment duration is based on animal data and is generally recommended by HIV Specialists.

If an HCW presents for evaluation of a high-risk exposure at a time >36 hours after the incident, rather than late initiation of PEP, close monitoring of the HCW for signs and symptoms of acute HIV infection is generally recommended with subsequent introduction of HAART if acute seroconversion occurs (see Figure 1 in the original guideline document, which provides a clinical algorithm for "PEP Following Occupational Exposure").

Recommended PEP Regimens

Clinicians should initiate three-drug ARV therapy for significant occupational exposures to HIV. The preferred PEP regimen is zidovudine 300 mg orally (po) twice a day (bid) + lamivudine 150 mg po bid (or Combivir 1 po bid) plus tenofovir 300 mg po once per day (qd), or Zidovudine300 mg po bid plus Emtricitabine 200 mg po qd + Tenofovir 300 mg po qd (or Truvada 1 po qd). Alternative agents may be used in the setting of drug intolerance or toxicity (see Table 3 and Appendix A in the original guideline document).

The PEP regimen should be continued for 4 weeks.

When the source is known to be HIV infected and information regarding previous ARV therapy, current level of viral suppression, or genotypic/phenotypic resistance profile is available, the clinician, in consultation with an HIV Specialist, should individualize the regimen to more effectively suppress viral replication.

Monitoring the HCW Following Occupational Exposure

Clinicians should closely monitor people receiving PEP to detect ARV-induced toxicities (See the National Guideline Clearinghouse [NGC] summary of the New York State Department of Health [NYSDOH] guideline Antiretroviral Therapy for monitoring recommendations).

Because of the complexity and potential adverse effects of the treatment regimens, longitudinal care of the exposed HCW should be provided either directly by or in consultation with an HIV Specialist or an experienced occupational health clinician who is familiar with the most current PEP guidelines.

Sequential confidential HIV testing should be obtained at baseline, 1, 3, and 6 months post-exposure even if PEP is declined (see Table 4, "Monitoring Recommendations after Initiation of PEP Regimen Following Occupational Exposure Among HCWs" in the original guideline document). In New York State, if the test result is positive, a Western blot assay must be performed to confirm the diagnosis of HIV infection. See Appendices D and E of the original guideline document for specific counseling recommendations.

If the HCW presents with signs or symptoms of acute HIV seroconversion, immediate consultation with an HIV Specialist should be sought for optimal diagnostic testing and treatment options.

The HCW should be evaluated weekly over the first month to assess PEP adherence, adverse effects of the ARV therapy, interval physical complaints, and emotional status. (See the NGC summaries of the NYSDOH guidelines Antiretroviral Therapy, Long-Term Complications of Antiretroviral Therapy, and HIV Drug-Drug Interactions for monitoring recommendations, adverse drug effects, and important drug interactions, respectively).

PEP for the Pregnant HCW

Before administering PEP to a pregnant woman, the clinician should discuss the potential benefits and risks to her and to the fetus. Drugs to avoid during pregnancy include the following:

- Efavirenz
- Combination of stavudine and didanosine
- Unboosted indinavir in the second and third trimester

Based on increasing clinical experience with HAART, PEP is indicated at any time during pregnancy when a significant exposure has occurred, despite possible risk to the woman and the fetus. Expert consultation should be sought. When PEP is indicated, it should be initiated ideally within 2 hours and generally no later than 36 hours post-exposure.

Efavirenz, which has been associated with teratogenicity in monkeys, should not be used in pregnant women.

The combination of didanosine and stavudine should be avoided due to an increased risk of mitochondrial toxicity in pregnant women.

Unboosted indinavir should not be used in pregnant women in the second or third trimester due to a substantial decrease in antepartum indinavir plasma concentrations.

Clinicians should advise women who may have been exposed to HIV through occupational exposure to avoid breastfeeding for 6 months after the exposure.

Occupational PEP for Hepatitis B and C

The hepatitis B vaccine series should be initiated in non-hepatitis B virus (HBV)-immune HCWs who sustain a blood or body fluid exposure.

Administration of prophylactic hepatitis B immune globulin (HBIG) and the initiation of the hepatitis B vaccine series (at different sites) are recommended when the non-HBV-immune HCW sustains a blood or body fluid exposure to a source with known acute or active HBV (see Table below).

Following an occupational exposure, the source patient's HBV and hepatitis C virus (HCV) serologic status should be determined.

If the source patient is known to be HCV-antibody positive or if the serostatus is unknown, baseline HCV serology and serum alanine aminotransferase (ALT) should be obtained from the exposed HCW and should be repeated at 4 to 6 months post-exposure.

If the source patient is known to be HCV-antibody positive, an HCV antibody and qualitative HCV viral load (HCV ribonucleic acid polymerase chain reaction [RNA PCR]) should be obtained from the exposed HCW 4 weeks after exposure.

In the setting of an acute elevation of ALT in the exposed HCW in the first 24 weeks post-exposure, a qualitative HCV RNA PCR should be obtained.

When HCV infection is identified early, the HCW should be referred for medical management to a clinician with experience in treating HCV.

Table
Recommended Post-Exposure Prophylaxis for Occupational Exposure to Hepatitis B Virus

Vaccination and/or Antibody Response Status of Exposed Patient*	Treatment when Source Is:		
	HBsAg Positive	HBsAg Negative	Source Unknown or not Available for Testing
Unvaccinated/	HBIG (dose 0.06	Initiate	Initiate HB

Table Recommended Post-Exposure Prophylaxis for Occupational Exposure to Hepatitis B Virus			
Vaccination and/or Antibody Response Status of Exposed Patient*	**Treatment when Source Is:**		
	HBsAg Positive	**HBsAg Negative**	**Source Unknown or not Available for Testing**
non-immune	mL/kg intramuscularly) x 1; initiate HB vaccine series	HB vaccine series	vaccine series
Previously vaccinated, known responder**	No treatment	No treatment	No treatment
Previously vaccinated, known non-responder**	HBIG (dose 0.06 mL/kg intramuscularly) x 2 or HBIG (dose 0.06 mL/kg intramuscularly) x 1 and initiate revaccination***	No treatment	If known high-risk source, treat as if source were HBsAg positive
Previously vaccinated, antibody response unknown	Test exposed person for anti-HBs: • If adequate**, no treatment • If inadequate**, HBIG x1 and vaccine booster	No treatment	Test exposed person for anti-HBs: • If adequate**, no treatment • If inadequate**, initiate revaccination

Reprinted from the Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-Exposure Prophylaxis. *MMWR Morb Mortal Wkly Rep* 2001;50(RR-11):1-42. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm.

HBsAg, hepatitis B surface antigen; HBIG, hepatitis B immune globulin; anti-HBs, antibody to hepatitis B surface antigen.

*Persons who have previously been infected with HBV are immune to re-infection and do not require PEP.
** Responder is defined as person with adequate levels of serum antibody to HBsAg (serum anti-HBs ≥10mIU/mL); non-responder is a person with inadequate response to vaccination (serum anti HBs <10mIU/mL).
*** The option of giving one dose HBIG and re-initiating the vaccine series is preferred for non-responders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

CLINICAL ALGORITHM(S)

An algorithm is provided in the original guideline document for "Post-Exposure Prophylaxis (PEP) Following Occupational Exposure."

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

Because there are no clinical trials on which to definitively base recommendations, the New York State Department of Health AIDS Institute (NYSDOH AI) guidelines are based on best practice evidence and constitute the considered opinion of a group of expert clinicians in the field of adult human immunodeficiency virus (HIV) medicine.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Effective management of post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) and hepatitis B and C virus in health care workers
- Reduction in risk of transmission of HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV) after occupational exposure

POTENTIAL HARMS

- Medications used for post-exposure prophylaxis have risks of toxicity. Please refer to Appendix A of the original guideline document for information on toxicity, dose adjustments, and use in pregnancy for specific antiretroviral (ARV) drugs.
- Although birth defects and adverse effects on human fetuses have generally not been associated with the currently available ARV agents, exposure of a fetus to ARV agents during pregnancy carries a theoretical risk of teratogenicity.
- Human immunodeficiency virus (HIV) testing can result in a false-negative test.

CONTRAINDICATIONS

CONTRAINDICATIONS

- In the setting of renal insufficiency, tenofovir and lamivudine may require dose reduction or be contraindicated (refer to Appendix A of the original guideline document for additional information).
- Efavirenz, which has been associated with teratogenicity in monkeys, should not be used in pregnant women.
- Unboosted indinavir should not be used in pregnant women in the second and third trimester due to a substantial decrease in antepartum indinavir plasma concentrations.
- The combination of didanosine and stavudine should be avoided due to an increased risk of mitochondrial toxicity in pregnant women.

QUALIFYING STATEMENTS

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The New York State Department of Health AIDS Institute (NYSDOH AI) recommendations differ from those published by the Centers for Disease Control and Prevention (CDC) (see Appendix B in the original guideline document). The consensus opinion of the guideline committee continues to support a more aggressive approach to block human immunodeficiency virus (HIV) infection after occupational exposure. The recommendation to initiate post-exposure prophylaxis (PEP) must take into account the potential benefit of preventing infection versus the risk of toxicity from the medications used for PEP.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with HIV infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDOH) Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards
Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. HIV prophylaxis following occupational exposure. New York (NY): New York State Department of Health; 2008 Jan. 22 p. [17 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Mar (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Medical Care Criteria Committee

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: New York State Department of Health. HIV prophylaxis following occupational exposure. New York (NY): New York State Department of Health; 2004 Jun. 41 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Appendix A: antiretroviral drugs. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.
- Appendix B: occupational Exposure to HIV: comparison of NYSDOH and CDC Recommendations. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.
- Appendix C: informed consent form. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.
- Appendix D: HIV counseling and education for healthcare workers after an occupational exposure. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.

- Appendix E: post-test counseling following occupational HIV exposure. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.
- Appendix F: post-exposure management: employer issues and responsibilities. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.
- Recommendations for HIV postexposure prophylaxis (PEP). Quick reference card. New York (NY): New York State Department of Health; 2004 Feb. 2 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Occupational exposure - management of HIV post-exposure prophylaxis. Slide presentation. New York (NY): New York State Department of Health; 2002. Electronic copies: Available in PowerPoint from the New York State Department of Health AIDS Institute Web site.

This guideline is also available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on March 18, 2004. This NGC summary was updated by ECRI on January 11, 2005. This NGC summary was updated by ECRI Institute on September 19, 2007. This NGC summary was updated by ECRI Institute on June 27, 2008.

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